STATEMENT OF FINANCIAL POLICY

Our primary goal is to provide quality professional services for our clients and to be sensitive to the financial concerns that they express. We are providing this formal statement in order to fully disclose our policies and expectations. By executing this agreement you are agreeing to pay for all services that are rendered.

FINANCIAL AGREEMENT

All co-pays and services not covered by your insurance are due at the time of service. For the testing clients covered by insurance, other than Medicaid, CareSource, or BWC, there is a $20.00 testing materials fee due at the time of the first date of service, which is not payable by insurance. It is the responsibility of the undersigned to track the limits of their insurance coverage, to ensure that treatment is authorized. The undersigned hereby authorizes the release of any information necessary to process insurance claims and request payment of benefits to The Flexman Clinic. The undersigned hereby assigns and authorizes payment to be made directly to The Flexman Clinic for all insurance benefits, and agrees to pay any remaining balance due. The undersigned also acknowledges their responsibility for any additional fees incurred, including testing materials fees, returned checks, late cancellation/no-show fees, copies of medial records, and late or non-payment of account balances. PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR COVERAGE. WE DO NOT OFFER DISCOUNTS (i.e. WRITE OFF CO-PAYS, REDUCED FEES OR COLLECTION INSURANCE ONLY, ETC; THIS IS ILLEGAL).

If you have a medical card please present it to the receptionist for verification before each session. There will be a $50.00 charge for any returned checks. We do not accept post-dated checks.

A detailed list of all charges for our services can be obtained upon request from our front office personnel.

If you have insurance, please provide us with a complete insurance form and/or your card. We will file your insurance for you. You are responsible for paying your co-pay at the time of each visit, and you are responsible for any charges not covered by your insurance. You are responsible for keeping track of the limits of your coverage, and to make sure your sessions are authorized. Due to the changes which occur frequently with insurance plans, it has become increasingly difficult for us to keep track of every insurance plan that requires special authorization or timing of submission of claims. Therefore, it is the understanding of the undersigned that for any reason the insurance company denies charges associated with the care provided by The Flexman Clinic, the undersigned is completely responsible for all such charges.

If for ANY reason your insurance fails to pay for services, you agree that you are responsible for these charges.

There is a $35.00 charge for paperwork that has to be filled out by your therapist. For additional letters of compiled information there is a $75.00 minimum charge.

DIVORCE

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

CANCELLATION POLICY

Your appointment time is reserved especially for you. We cannot double book appointment times. We must receive notice of cancellation at least 24 hours in advance. There is a $50.00 charge for a late cancellation or missed appointment. This charge is payable by you, as it cannot be billed to your insurance. If you consistently miss your appointments without prior cancellation notice of at least 24 hours, or consistently no-show, we reserve the right to suspend services and to refer you to another agency. Remember, an appointment made is an appointment paid.

YOUR ACCOUNT WILL BE TURNED OVER FOR COLLECTION PROCESS IF NO PAYMENT IS MADE WITHIN 90 DAYS OF THE LAST SESSION. A FEE OF 30% OF THE BALANCE WILL BE ADDED IN SUCH CASES. AFTER YOU RECEIVE YOUR INITIAL STATEMENT, EACH ADDITIONAL STATEMENT SENT TO YOU FOR PRIOR SERVICES WILL INCLUDE A $25.00 HANDLING FEE. IF NCESSARY, PLEASE SET UP A PAYMENT PLAN TO AVOID INCURRING THESE FEES.

RECORDS REQUEST

Any request for copies of records to be sent to another entity needs to be in writing, with an appropriate release of information. There is a charge for records requested by a patient representative i.e., lawyer or insurance company. If the representative does not reimburse within 30 days from when the records are processed, the patient may assume responsibility for the charges. If the request is to transfer to another doctor, you authorize us to include all relevant information, including your payment history. Copies of medical records will be charged at the current rate of copying and handling, and payment is due prior to records being delivered to the requestor. The only exception is records requested from a representative of the Bureau of Disability Determination for Social Security purposes only.

CONSENT TO TREAT

It is understood that my/our clinical records are confidential and will not be released to other persons or agencies without my/our written authorization, except as allowed by law. The undersigned hereby grants permission to undergo psychological and/or psychiatric examination, evaluation, testing or therapy for the purposes of determining diagnosis and/or treatment or other professional mental health counseling services which are consistent with an individualized treatment plan to be developed with my knowledge and consent. Clients are expected to take responsibility for setting their own appointments. It is a good idea to keep several weeks of appointments on the book, in order to ensure getting the time of day or the day needed.

Fee schedule available upon request.

I, the undersigned, understand that should I miss an appointment at The Flexman Clinic or cancel an appointment with less than 24 hours notice, I may be charged up to a $50.00 fee.*

I, the undersigned, understand that for my evaluation with Dr. Flexman, which includes testing, there is a one time testing materials fee of $20.00 that must be paid before my next appointment may be scheduled. This fee is an office fee that cannot be billed to insurance. This fee does not apply to those with active Medicaid or CareSource insurance.

I, the undersigned, understand that should I miss or late cancel an appointment and be charged a fee, I will be required to pay all fees before I can be scheduled for my next appointment.

_____ _____

Signature of Client or Client's Representative Date

_____ _____

Signature of Flexman Clinic Witness Date

*Active Medicaid and CareSource insurance patients will not be charged a fee for missed appointments, however, The Flexman Clinic reserves the right not reschedule the client for an appointment due to a missed or late-cancelled appointment.